Health Services
LOS ANGELES COUNTY



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June 19, 2007 **REVISED**

TO: Each Supervisor

FROM: Bruce A. Chernof, M.D.
Director and Chief Medical Officer

SUBJECT: **CORRECTIVE ACTION PLAN FOR IMMEDIATE JEOPARDY**

This is to provide you with a copy of the Plan of Correction submitted last night, as required, to the Centers for Medicare and Medicaid Services (CMS) to address CMS' findings of an immediate jeopardy situation during their survey in the Emergency Department at Martin Luther King Jr. – Harbor Hospital (MLK-H) on June 7, 2007 and reported to the hospital on June 12, 2007.

The basis for the immediate jeopardy finding focused on three main areas that CMS identified:

The first finding involved a patient who required transfer for a neurosurgical condition (neurosurgery is a specialty not available at MLK-H). We have established a transfer process for neurosurgical patients that calls for immediate transfer of patients with specific neurosurgical diagnoses to our other hospitals on a rotating basis. We have also established a monitoring plan to ensure that these transfers occur expeditiously.

The second finding was the performance of medical screening exams by physician's assistants. Although physician's assistants may perform medical screening exams as part of their scope of practice, they must be specifically credentialed for this. CMS' concluded that the credentialing process had not been completed as required under the federal Emergency Medical Treatment and Active Labor Act (EMTALA). As a result of this finding, on June 12, 2007 MLK-H leadership directed California Emergency Physicians (CEP), the emergency department contract group, to immediately discontinue the use of physician's assistants for medical screening exams. These exams will now be performed only by the Emergency Department attending physicians. Additionally, MLK-H has discontinued the use of non-emergency physician's assistants as consultants in the Emergency Department.

The third finding related to the timing of the medical screening exam. CMS found that there were delays in completing medical screening exams for patients presenting to the Emergency Department. To address this deficiency, the leadership in the Emergency Department, Nursing, and Hospital Administration redesigned the process by which patients are seen in the Emergency Department. That redesign includes co-locating nursing and registration staff in the triaging area (the initial point of contact with the patient) with physicians available so that an immediate medical screening can be completed. Further, training was provided to emergency room nurses to ensure that physicians are contacted if management is needed prior to the medical screening exam.

Another important finding was that there were repetitive delays in care related to coordination of services. In each instance, appropriate multidisciplinary interventions have been developed, and implemented with appropriate monitoring put in place. The hospital had previously added an additional hospitalist physician (inpatient doctor) to improve patient care and patient transfers.

These findings are not acceptable and are discouraging in the face of the enormous effort to reform the hospital. They are grave and must be cured or the facility cannot continue to operate. Each citation has a definitive corrective action with close monitoring. We believe that these corrective actions fully address CMS' concerns and that CMS will release the immediate jeopardy finding. We expect CMS to return to the hospital to validate these corrective actions within the next week.

If you have any questions or need additional information, please let me know.

BAC:jrc

Attachment

c: Chief Administrative Officer
County Counsel
Executive Officer, Board of Supervisors

MARTIN LUTHER KING, JR.
HARBOR HOSPITAL



June 18, 2007

**Via Facsimile and United States Mail**

Steven D. Chickering
Western Consortium Survey and Certification Officer
Centers for Medicare and Medicaid Services
Division of Survey and Certification
90 7th Street Suite 5-300(5W)
San Francisco, CA 94103-6707

Dear Mr. Chickering:

**IMMEDIATE JEOPARDY NOTICE: CCN 05-0578 – MARTIN LUTHER KING, JR. HARBOR HOSPITAL**



Attached for your consideration is the Plan of Correction prepared by Martin Luther King, Jr.-Harbor Hospital ("MLK-Harbor") in response to the Centers for Medicare and Medicaid Services' ("CMS") notice of intent to terminate the hospital's participation in the Medicare program because of immediate jeopardy to patient health and safety. Also attached are the various documents which are referenced in that Plan of Correction. Together these materials credibly demonstrate that the actions necessary to correct the immediate jeopardy to patient health and safety have been taken, such that CMS may remove its finding, and return to the terms of the Extension Agreement between the parties.

We have included in the beginning of the Plan of Correction a discussion of the five immediate correction actions outlined in Paragraph 1 of your June 12, 2007, letter, as well as the corrective action requested in Paragraph 2(a). The corrective actions discussed in the remainder of Paragraph 2 were incorporated into the responses to individual findings on the form 2567. More particularly, those responses include:

- Ceasing the use of Physician Assistants to provide medical screening examinations so that only licensed and credentialed physicians will perform those examinations (Paragraph 2(b)).
- Redesigning the triage/intake process so that the provision of medical screening examinations is assured (Paragraph 2(c)).
- Training its emergency room nurses to contact a physician whenever a patient awaiting care in the emergency room waiting area requires an intervention for pain and not to wait for the screening examination.
- Implementing a new protocol to expedite the transfer of neurosurgical patients, and instituting a "no refusal" policy which requires sister county hospitals to accept such patients promptly. In addition, a mechanism was created to assure that high level clinical contacts are made whenever difficulty is encountered in transferring patients of any kind (Paragraph 2(e).

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- Assigning a hospitalist to the emergency room to manage individuals who have internal medicine or certain other issues and are awaiting transfer or admission (Paragraph 2(d)). The assignment of a dedicated hospitalist, who will be in the emergency department 24/7, will assure that those patients receive the level of physician attention that they would if they were admitted; and also will help remove impediments to patient transfers. To assure the proper stabilization and treatment for patients who will continue to be managed by the emergency physicians, the emergency physicians have received reinforcing education on documentation, and continuing assessment responsibilities. A requirement for the physician to assess each patient at the beginning of each shift has been added and compliance is being monitored.

- Developing a monitoring plan for every corrective action, aside from individual counseling, generally involving daily or weekly chart review, and remediating deficiencies immediately if they continue. Moreover, the data from such monitoring is provided to the Performance Improvement Committee for its use and integration into MLK-Harbor's quality improvement program (Paragraph 2(g) and (h).)

No corrective actions have been implemented with respect to Patient P, as we believe that survey findings do not accurately reflect the actual care received by this individual. For example, those findings do not reflect that the patient received a medical screening examination within less than 2 hours of presenting to the emergency room, and that after receiving some diagnostic tests, including an ultrasound, she was seen by a specialist at 1600 hours. That specialist determined that the proper course of treatment was simply observation of the patient, which occurred while the patient was awaiting inpatient placement. That placement took place at 2000, not at 2100 as noted by the surveyor. Thus, the patient did timely receive the medical care appropriate to her clinical situation, and no corrective actions were necessary.

We note that, as of June 17, 2007, MLK-Harbor had not been provided with a key to identify the specific patients for whom there were findings. While it believes that it is has determined who most of the patients are, it reserves the right to develop and present additional corrective actions after CMS has disclosed the identity of those patients.

Notwithstanding that reservation, MLK-Harbor believes that significant, appropriate corrective actions have and will continue to be made which assure the safety and timely treatment of patients who present to its emergency department. Accordingly, we urge CMS to authorize a resurvey and to revoke its decision to terminate the hospital on June 30, 2007.

If you have any questions regarding the attached materials, please do not hesitate to contact me.

Sincerely,

Antionette Smith Epps
Administrator

ASE:rs

Attachments

c: Michelle Griffin
Jackie Lincer
Bruce A. Chernof, MD

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETION DATE |
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| A 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the Department of Health Services during investigation of EMTALA complaint # 117102.<br><br>Representing the Department of Health Services:<br>JoAnn Dalby, R.N., Health Facilties Evaluator Supervisor<br>Sanford Weinstein, M.D., Medical Consultant<br>Barbara Mellor, R.N., Health Facilities Evaluator Nurse | A 000 | In response to the letter from the Centers for Medicare and Medicaid services (CMS) , the following actions were taken:<br>**REASSIGNMENT OF PHYSICIAN ASSISTANTS**<br>a. The Chief Medical Officer notified the ED Medical Director that physician assistants shall no longer perform medical screening examination. (Attachment A) The ED Medical Director informed each physician assistant by e-mail that they may no longer perform individual medical screening examination.<br>**COMPETENCY TO PERFORM MEDICAL SCREENING EXAMS**<br>b. See attached. (Attachment B)<br>**NUMBER AND QUALIFICATIONS OF STAFF ASSIGNED**<br>c. Attached is a schedule of the number of persons assigned to the emergency and urgent care services, broken down by job classification and qualifications. (Attachment C)<br>**NUMBER AND QUALIFICATIONS OF STAFF NEEDED**<br>d. Attached is a schedule of the number of full time equivalents (FTE), needed in the emergency department areas, including their qualifications and scope of duties and assignment. (Attachment D) | 6/19/07 |
| A 455 | 482.55(a)(2) INTEGRATION OF EMERGENCY SERVICES<br><br>The services must be integrated with other departments of the hospital.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the hospital failed to ensure the timely provision of emergency services to meet the needs of 17 of 60 sampled patients presenting for evaluation of an emergency medical condition. ( Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q). The hospital failed to:<br>1. Follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were conducted by appropriately qualified individuals.<br>2. Ensure on - call physicians saw patients when specialty consultation was required.<br>3. Ensure pain managment was provided in a timely manner,<br>4. Provide stabilizing treatment for emergency medical conditions.<br>5. Ensure timely transfer of individuals who required services not available at the hospital.<br><br>The cumulative effect of these systemic failures | | Historical volume data (e.g., census) are used to establish the staffing requirements. Nursing management has access to and uses an automated system to adjust required staffing on a shift-by-shift basis. The ED Medical Director maintains a schedule of the physician staffing needs for the Emergency Room and Adult Urgent Care and he/she is responsible for adjustments on a shift-by-shift basis. The Pediatrics Urgent Care Director or Chief of Pediatrics maintains a schedule of the physician staffing needs and he/she is responsible for adjustments on a shift-by-shift basis. The Department of Women's and Child's Health is independently responsible for the services. Rosters of qualified personnel are maintained by the responsible managers. | 6/19/07 |

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|---|---|---|
| [signature] | CEO | 6/18/07 |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| A 000 | INITIAL COMMENTS<br><br>The following reflects the findings of the Department of Health Services during investigation of EMTALA complaint # 117102.<br><br>Representing the Department of Health Services:<br>JoAnn Dalby, R.N., Health Facilties Evaluator Supervisor<br>Sonford Weinstein, M.D., Medical Consultant<br>Barbara Mellor, R.N., Health Facilities Evaluator Nurse | A 000 | A000 (continued)<br>**METHOD/PROCESS ACCOUNTING FOR INDIVIDUALS SEEKING EMERGENCY SERVICES**<br>e. As part of the triage process, each individual seeking emergency medical services is directed by signage, to the triage window and is manually logged in by a licensed nurse, as well as is entered into the emergency room central log by the registration clerk. At that point, patients are provided with an identification wristband, which they maintain until their discharge.<br><br>Patients brought in by ambulance are received in the emergency treatment area by registered nurse who notifies the registration staff. Registration staff enters the patient into a manual log, and then into the central log, and the patient is given an identification wristband.<br><br>As a way to assure that all patients are captured by this process, the nursing shift supervisor includes the ED waiting room on shift rounds each shift. The Nursing Shift Supervisor selects two patients in the waiting room and validates that these two patients have been appropriately and timely triaged and that each patient has been entered in to the central log. In the event that discrepancies are discovered, immediate corrective actions are taken.<br><br>To assure that each of the correction actions discussed below are fully implemented and monitored, the Director of Quality Improvement will track each corrective action, and report on her findings to the Quality Council. The Quality Council reports its findings and follow-up actions to both the Executive Committee and the Governing Body. | 6/19/07<br><br>5/16/07 |
| A 455 | 482.55(a)(2) INTEGRATION OF EMERGENCY SERVICES<br><br>The services must be integrated with other departments of the hospital.<br><br>This STANDARD is not met as evidenced by:<br>Based on observation, interview and record review, the hospital failed to ensure the timely provision of emergency services to meet the needs of 17 of 60 sampled patients presenting for evaluation of an emergency medical condition. ( Patients A, B, C, D, E, F, G, H, I, J, K, L, M, N, O, P, Q). The hospital failed to:<br>1. Follow their policies and procedures (P&P), by-laws, rules and regulations developed to ensure medical screening examinations were conducted by appropriately qualified individuals.<br>2. Ensure on - call physicians saw patients when specialty consultation was required.<br>3. Ensure pain managment was provided in a timely manner,<br>4. Provide stabilizing treatment for emergency medical conditions.<br>5. Ensure timely transfer of individuals who required services not available at the hospital.<br><br>The cumulative effect of these systemic failures | | | |

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| A 455 | Continued From page 1<br>resulted in an immediate threat to the health and safety of all patients presenting for treatment at the Emergency Department. At approximately 1530 hours on 6/7/07, hospital administration was notified of the immediate jeopardy.<br><br>Findings:<br><br>1. Patient A presented to the ED (emergency department) on 2/28/07 at 0950 hours, with a chief complaint of headache (comes and goes) with occasional nausea. At the time of triage, 1003 hours, the patient described that he was experiencing severe pain, that scored nine out of 10, on a scale of one to 10, with 10 being the most severe. The patient described that the pain was located at the back of his head and that it was relieved by vomiting. The patient was assigned a triage acuity of three. Per hospital policy, an acuity of three indicated the patient had a major illness or injury, but was stable.<br><br>At 1250 hours, Patient A was taken to the treatment area. Nursing assessment at that time revealed " steady gait " , pupil sizes of 33 and 31 mm. A Glascow Coma Scale score of 15 was recorded (a standardized series of observations reflecting speech, pain, orientation and speech. A score of 15 is normal).<br><br>Patient A was assessed by the emergency department physician, at which time "paraspinal tenderness" was noted, but no " Neuro" changes or " Psych" abnormalities recorded. A blood count revealed 16.4 gms. of hemoglobin and a white count of 10,800 (upper normal range). Morphine 4 mg was administered in the emergency department, however, the results of the medication administration was not recorded. | A 455 | **Patient A – Immediate Actions**<br>• ED nurse manager counseled the RN who gave morphine 4 mg, but did not receive the results of the medication administration. 6/19/07<br>• ED nurse manager educated all ED registered nurses on the requirements to record the results of medication administration. (Attachment C) 6/15/07<br><br>**Monitoring:**<br>Quality Improvement will review ten randomly selected charts weekly to assess documentation of results of pain medication. Deficiencies will be addressed by the ED Nurse Manager. Data from these reviews will be presented to the Performance Improvement Committee and to the Executive Committee.<br><br>**Responsible Position:**<br>Chief Nursing Officer<br>ED Nurse Manager | |

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| A 455 | Continued From page 2<br>A CT head scan was ordered by the ED physician .<br><br>At 1550 hours Patient A was taken to CT. The report revealed, "significant ventricular dilatation with periventricular changes consistent with subependymal edema. This may be related to a heterogeneous mass near the region of the pineal with caudal extension to a level near the proximal fourth ventricle." The scan revealed a brain tumor measuring approximately 2.5 cm. compressing the internal circulation of fluid in the brain resulting in internal swelling from dilatation of the ventricular system of the brain. An MRI image of the brain was recommended and completed. This confirmed the presence of a tumor mass in the region of the pineal gland. Moderate dilatation of the ventricular system of the brain was noted.<br><br>A handwritten note by the ED physician noted that Neurosurgery was not available at the hospital, " will arrange MAC transfer". (The MAC is the medical alert center for Los Angeles County. This is the central clearing house for all Los Angeles County hospitals.) However, there was no written documentation that physician to physician contact had been initiated. A clinical impression of "Acute Obstructive Hydrocephalus" was recorded. A physician order for a neurosurgery consult was written at 1653 hours on 2/28/07.<br><br>A "Neurology Consultation" handwritten by a Physician Assistant (PA-C) identified that the patient was seen for evaluation at 1720 hours. The consultation revealed no neurological defects or alteration in mental status for Patient A. The consult described symptoms of dizziness, nausea, headache and vomiting. The | A 455 | **Patient A - Background**<br>The Medical Alert Center (MAC) coordinates transfer of patients from MLK-H to other facilities. The MAC receives clinical data regarding the patient, and uses it to search fro an appropriate site for that patient. Once an appropriate site is identified, the MAC and the MLK-H Patient Flow Manager (or where appropriate, the physician) presents additional clinical data to the receiving. In this instance, there were no available neurosurgical beds within the County. The MAC continued efforts to locate an appropriate placement, however, an appropriate placement could not be found before the patient left AMA.<br><br>**Immediate Actions:**<br>• The emergency medicine attending (ED physician) at MLK-H will identify patients requiring neurosurgical intervention based on specific guidelines.<br>• A protocol has been established to require that all patients with specific neurosurgical clinical conditions receive timely transfer. (Attachment D)<br>• The ED physician or the Patient Flow Manager will then contact the MAC operator, informing him/her of the patient needing transfer.<br>• MAC determines the accepting/receiving facility based on a rotation schedule when it maintains.<br>• MAC will contact the Patient Flow Manager at the receiving facility regarding the need for the transfer.<br>• The Patient Flow Manager at the receiving facility promptly contacts the neurosurgeon on call and arranges the physician-to-physician contact. ED physician at MLK-H speaks directly with neurosurgeon at the receiving facility and provided a brief summary of the patient's findings.<br>• Any clinical suggestions by the receiving neurosurgeon, which are within the capability of the hospital and the scope of practice of the ED physician, will be incorporated into the pre-transfer plan of care. | 6/14/07<br><br>6/19/07 |

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| A 455 | Continued From page 3<br>consultation, provided by the PA-C, was then countersigned by the attending neurology physician at 1900 hours. No written note was provided by the neurology physician. The medical record failed to contain documented evidence that the neurologist had actually examined Patient A. This finding was in violation of the Medical Staff rules and regulations requiring a written note. The consultation request form revealed that "Stat MAC transfer to a facility with neurosurgical service" was required.<br><br>A written order for "MAC transfer to Neurosurgical facility was provided at 1717 hours by the attending ED physician. There was, however, no written documentation that any physician had actually spoken with or discussed the emergent clinical situation of Patient A with a proposed receiving hospital to facilitate transfer for Patient A. Documents contained in the medical record revealed that Patient A signed a transfer consent on 2/28/07.<br><br>At 0350 hours on March 1, 2007, nursing notes revealed that Patient A was administered Dilaudid (narcotic pain medication) by IVP (intravenously push). There was no documented evidence that a ED physician had examined or assessed the neurological status of Patient A. A nursing re-assessment performed at 0550 hours revealed that a neurocheck had been performed and the headache pain of Patient A had improved.<br><br>Additional nursing assessments were performed at 0730, 0900,1100, 1300, 1500, and 1830 hours. These nursing assessments documented no change in the status of Patient A These assessments indicated that Patient A was able to move all four extremities and remained alert. No | A 455 | • The respective facility Patient Flow Managers shall work with MAC to coordinate the transfer via ACLS transport.<br>• All appropriate and completed documents and imaging studies shall accompany the patient.<br>• If the ED physician determines that there is **ANY** impediment to the transfer, he/she shall contact the Chief Medical Officer at the receiving facility to facilitate the transfer.<br>• With respect to all patient transfers, regardless of patient diagnosis, a transfer log is maintained by MLK-H Patient Flow Manager. A multidisciplinary group meets Monday through Friday to review all transfers that have taken place based on this log, to resolve any issues identified from completed transfers, to facilitate patients waiting for transfer, and to update the status of patients requiring transfer. Any neurosurgical patients who are pending transfer will be reviewed as part of this process.<br>• MLK-H has identified a medical administrative Director in charge of patient flow. This Patient Flow Manger notifies the medical administrative Director whenever there are impediments to transferring a patient, including a neurosurgical patient, in a timely manner. The medical administrative Director will assure that there is high-level physician contact with potential receiving institutions in an effort to expedite transfer.<br><br>**Monitoring:**<br>• The Patient Flow Manager maintains a log of patient transfers. Data regarding patient transfers is aggregated and presented to Performance Improvement Committee and to the Executive Committee, and then to the Governing Body where appropriate.<br><br>**Position Responsible:**<br>Interim Chief Medical Officer | |

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| A 455 | Continued From page 4<br>physician assessments were documented.<br><br>Patient A remained in the ED until 3/3/07. Review of the medical record revealed that the patient was assessed by nursing staff and continued to received Dilaudid and morphine to control his headache pain. The nursing pain assessments included only a numerical score to identify the intensity of pain but failed to identify pain radiation, quality (ache, throbbing, sharp, dull, burning) and constancy as required by established hospital policy. The medical record failed to provide documented evidence that ED physicians provided on-going assessments and care. Except for the initial consult, the neurologist did not see the patient again.<br><br>On 3/3/07 at 0725 hours, nursing documentation identified that Patient A complained of occipital headache pain. Intensity of pain was recorded as 5/10. The patient was not given pain medication nor were non-medication interventions provided. Nursing documentation further identified that no deficits were noted. However, the very next sentence stated c/o (complaint of) blurred vision when ambulating. The patient was not evaluated for the neurological symptom by a physician.<br><br>At 1100 hours, Patient A complained of increased head pain. The patient identified the intensity of pain as being 9/10 (severe). The patient received Dilaudid 1 mg. IV for pain. Although a physician order was obtained for the pain medication, the patient's medical record failed to contain documented evidence that the ED physician evaluated the patient.<br><br>At 1150 hours, the patient and his family indicated that after three days, they were tired of waiting for | A 455 | **Immediate Actions:**<br>• The Interim Chief Medical Officer ordered all MLK Department Chiefs to discontinue the practice of using Physician Assistants for consultations in the ED. All ED consultations will be performed by an attending physician. (Attachment E) — 6/14/07<br>• The ED Nurse Manager provided a letter instructing all ED RNs regarding Physician Assistants cannot provide consults. (Attachment F) — 6/19/07<br>• The Interim Chief Medical Officer instructed all Department Chiefs to ensure that all attending physicians are aware of the need to document their consultations. (Attachment B). — 6/19/07<br><br>**Monitoring:**<br>• For the next 30 days, Monday through Friday, Quality Improvement staff will review ten randomly selected open medical records in the ED to validate that consults were performed by a physician and that there is a consulting physician's note. The Chair of the relevant department will be notified of discrepancies for immediate corrective action.<br>• Ten randomly selected ED records of patients will be reviewed each week to validate the presence of the attendees note. Results of these audits will be presented to Performance Improvement Committee, which will review and create corrective actions as necessary. This data will then be reported to the Executive Committee and to the Governing Body as appropriate. The Chair of the service will be notified of discrepancies for corrective actions.<br><br>**Position Responsible:**<br>Interim Chief Medical Officer | |

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| A 455 | Continued From page 5<br>transfer to another hospital. Patient A signed out AMA (against medical advise) to seek treatment elsewhere. The "Leaving Hospital against Medical Advice" form was noted to be incomplete. In addition, the medical record failed to contain documented evidence that at the time of discharge, the patient had been assessed by a physician or had received discharge instructions.<br><br>On 6/1/07 and 6/5/07 discussions with hospital staff regarding the care of Patient A and quality assurance, identified that the medical care received by Patient A was deemed to be appropriate. The hospital was requested to provide any and all documentation related to the patient's care as well as any quality of care reviews.<br><br>A case review summary for Patient A was received at 1340 hours on 6/5/07. The case review confirmed a failure of the ED physicians to document assessments of Patient A for three days. Further review of the summary identified that there was a system wide plan to provide neurosurgical services and to streamline the transfer process of patients between hospitals. Patient A was a pending transfer to a higher level of care on 3/3/07 prior to leaving the hospital against medical advice. As of 6/7/07, the plan had not been implemented.<br><br>2. Patient B presented to the emergency department on 3/8/07 at 2242 hours, with a chief complaint of stomach pain for the past two weeks . The nurse documented that the pain was in all four quadrants and radiated in to the patient's back. It was documented that the patient had multiple episodes of nausea and vomiting today. The patient identified her pain as being severe | A 455 | **Immediate Actions- Patient A:**<br>• The ED Medical Director provided education for all ED physicians on "change of shift and patient hand-off recommendations." This directive requires specific acknowledgement and documentation of the hand-offs on each shift. (Attachment H)<br>• A hospitalist position on all shifts was added to the Emergency Department team to assume responsibility for the care of internal medicine patients who are admitted to MLK-H and are awaiting a bed placement. If there are not beds available at MLK-H, the hospitalist assumes responsibility for facilitating the transfer. While the patient is awaiting transfer or admission, the hospitalist is responsible for writing holding orders, reassessing the patient periodically, and modifying the plan of care as required. However, the ED physicians remain responsible for neurosurgical, orthopedic and psychiatric patients awaiting transfer and other departments would assume responsibility for their patients.<br>• For the ED physicians, the smart chart (a physician documentation record, which is a tool, used to assure consideration of important clinical questions) was implemented to improve physician documentation and to capture encounter times.<br>• The ED Medical Director informed ED physicians at a department meeting, and followed-up with a written directive to all ED physicians, that they were responsible for assessing all active patients and patients waiting for transfer at the beginning of each shift. They were also informed of their responsibility to meet with oncoming physicians at the | 6/9/07<br><br>3/07<br><br>3/07<br><br>6/9/07 |

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| A 455 | Continued From page 6<br>with a score of 10 out of 10. The patient identified that the pain she was experiencing was constant and that nothing provided relief. The pain was further described as aching and burning with a pressure sensation. Nursing documentation revealed that the patient was moaning and had facial grimacing. Vital signs were recorded as Temperature 102.8 degrees, heart rate 97, respirations 24 and blood pressure was 133/59. No treatment was provided to alleviate pain or reduce the patient's fever at the time of triage. The patient was assigned a triage category of 3. Category or Level 3 patients are described as having a stable major injury or illness.<br><br>Two hours later, at 0040 hours, Patient B's vital signs were re-assessed. The patient had a temperature of 102.4 degrees, heart rate 102, respirations 20 and blood pressure was recorded as 118/62. The patient continued to experience severe abdominal pain. No treatments were provided in the triage area.<br><br>At 0110 hours, the patient was transferred to the treatment area. The patient continued to have severe pain, recorded as 7/10. The patient received Tylenol 650 mg. and was placed on oxygen by mask. At 0220 hours, the patient was described to have decreased pain. At 0400 hours, nursing documentation revealed that the patient had no orders for care and was waiting for the physician assistant. This was approximately three hours after she was taken to the treatment area of the ED.<br><br>Patient B was not evaluated by a physician until 0530 hours The patient was described as having a fever and was in moderate to severe distress. The patient continued to experience severe pain | A 455 | **Immediate Actions – Patient B: (cont'd)**<br>• The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain at a level, which requires intervention based on the pain policy. This information must be documented in the patient's medical record. (Attachment L)<br>• A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triaging process was re-designed to provide for a more timely medical screening exam. This process includes the following: (Attachment O)<br>o The triage nurse and registration clerk are co-located so that the triaging process and the registration process can occur simultaneously.<br>o A physician will be available to the triaging area to perform immediate medical screening examinations for patients who are identified as a level 3. Upon completion of the medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out.<br>o Patients who are identified as a Level 1 and 2 at the time of triage will be brought back to the emergency treatment area. At the time of arrival, the ED charge nurse will notify the physician of the patient's arrival by placing the patient's pseudo name on the white board along with the patient's priority number. The physician will acknowledge the patient by initialing the white board and will perform the medical screening examination as soon as possible. If a patient's condition is critical, the RN will verbally notify the physician. | 6/21/07<br><br>6/21/07 |

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| A 455 | Continued From page 7<br>and nausea. The patient experienced severe pain throughout her ED stay.<br><br>At 0950 hours, 11 hours after presenting to the ED, the patient was transferred to surgery services to undergo an exploratory laparotomy.<br><br>3. The medical record for Patient D documented the teenager presented to the emergency department (ED) at 2355 hours on 2/12/07 with right abdominal pain. He was triaged by the nurse and determined to have pain of 10 on a 1-10 scale (10/10). His oxygen saturation level was 100%, his pulse 95 respirations were 18 and his blood pressure was 113/69. At 0040 hours the nurse documented the patient was complaining of difficulty breathing. The nurse documented he had wheezing in his lungs, his respiratory rate was 22 , blood pressure was 135/70, oxygen saturation was 97% and that he was anxious and restless. There was no documentation about why he was left in the lobby of the ED. No pain medication or other pain relieving interventions were provided. There was no re-assessment of the patient until he was taken to a treatment area five hours later. At 0530 hours on 2/13/07 his pain was 8/10. At 0645 hours laboratory tests and pain medication were ordered for Patient D. The pain medication was administered at 0840 hours; approximately 8 and 1/2 hours after he presented to the ED. The laboratory test results were not available until 2100 hours. This was approximately 14 hours after they were ordered and 19 hours after Patient D came to the ED. There was no documented evidence the nursing | A 455 | **Monitoring:**<br>• Ten randomly selected medical records will be reviewed daily to track the time from triage to medical screening examination. Data from these daily reviews will be presented to the ED Collaborative Practice Committee and the process will be re-evaluated as a result of this review. Data will also be presented to the Performance Improvement Committee monthly which will evaluate it, create corrective actions as necessary, and report it to the Executive Committee and as appropriate, the Governing Body.<br><br>**Position Responsible:**<br>ED Medical Director<br>ED Nurse Manager<br><br>**Immediate Actions – Patient D:**<br>• The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires interventions based on the pain policy.<br>• A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triaging process was re-designed to provide for a more timely medical screening examination. This process includes the following:<br>o The triage nurse and registration clerk are co-located so that the triaging process and the registration process can occur simultaneously.<br>o A physician will be available to the triaging area to perform immediate medical screening examinations for patients who are identified as a level 3. Upon completion of the medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out.<br>o Patients who are identified as a Level 1 and 2 at the time of triage, will be brought back to the emergency treatment area. At the time of arrival, the ED charge nurse will notify the physician of the | 6/19/07<br><br>6/21/07 |

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| A 455 | Continued From page 7<br>and nausea. The patient experienced severe pain throughout her ED stay.<br><br>At 0950 hours, 11 hours after presenting to the ED, the patient was transferred to surgery services to undergo an exploratory laparotomy.<br><br>3. The medical record for Patient D documented the teenager presented to the emergency department (ED) at 2355 hours on 2/12/07 with right abdominal pain. He was triaged by the nurse and determined to have pain of 10 on a 1-10 scale (10/10). His oxygen saturation level was 100%, his pulse 95 respirations were 18 and his blood pressure was 113/69. At 0040 hours the nurse documented the patient was complaining of difficulty breathing. The nurse documented he had wheezing in his lungs, his respiratory rate was 22 , blood pressure was 135/70, oxygen saturation was 97% and that he was anxious and restless. There was no documentation about why he was left in the lobby of the ED. No pain medication or other pain relieving interventions were provided. There was no re-assessment of the patient until he was taken to a treatment area five hours later. At 0530 hours on 2/13/07 his pain was 8/10. At 0645 hours laboratory tests and pain medication were ordered for Patient D. The pain medication was administered at 0840 hours; approximately 8 and 1/2 hours after he presented to the ED. The laboratory test results were not available until 2100 hours. This was approximately 14 hours after they were ordered and 19 hours after Patient D came to the ED. There was no documented evidence the nursing | A 455 | • As part of the monthly laboratory quality assurance program, the time from request to the time of receipt of specimen will be tracked and trended and corrective actions based on the data will be recommended to the Quality Improvement Committee, then reported to the Executive Committee and the Governing Body as appropriate.<br>o Ten randomly selected open medical records will be reviewed each week to track the time from when the labs are ordered to the time quality improvement activities will immediately add reassess prolonged times with the RN assigned and the ED Nurse Manager for immediate actions. the results are placed in the chart. Results of these audits will be reported to the Performance Improvement Committee which will review and create corrective actions as necessary. The data will then be reported to the Executive Committee.<br><br>**Position Responsible:**<br>Director of Pathology<br>ED Medical Director<br>ED Nurse Manager | 6/19/07<br><br>6/19/07 |

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| A 455 | Continued From page 8<br>or medical staff were following-up to ensure the laboratory test results were obtained. During interviews on 6/1/07 medical staff stated this patient "fell through the cracks."<br><br>4. a. The medical record for pediatric Patient C showed she presented to the emergency department at 1030 hours on 3/20/07 for vomiting, lethargy, cough and congestion. She had a history of a ventriculoperitoneal shunt for hydrocephalus and began to feel bad after a visit to the dentist. Documentation shows the presence of a shunt malformation and/or infection was being ruled out. A neurology consult was ordered. At 1230 the physician's assistant (PA) saw the patient to perform the neurology consultation. There was no documented evidence a neurologist saw the patient; however, the PA documented the recommended plan, in consultation with the neurologist, would be evaluation and management by a neurosurgeon on an urgent basis to assess the functioning of the shunt. Since neurosurgeons were not available at the hospital the PA recommended transfer to another hospital. The child was in the emergency department until 2200 hours but there was no documented evidence a neurosurgeon was contacted or that efforts were made to transfer the patient to a hospital with this service available. The patient was discharged to the mother's care.<br><br>4. b. At 1215 hours on 3/20/07 radiological tests of Patient C's shunt was ordered. Documentation shows the patient went to x-ray at 1325 hours but the tests were not performed because the radiology department did not know what to do. At 1415 hours the patient was again sent to the radiology department for the tests. The test | A 455 | **Immediate Action – Patient C:**<br>• The Interim Medical Director directed the chairs of the Department of Medicine, Women's and Child Health and Surgery that physician assistants will no longer be conducting medical consultations in the ED. (Attachment R)<br>• It was determined that there was no longer a need for neurosurgical transfer based on the results on of the shunt series, but this was not clearly documented. The Chair of Department of Women's and Child's Health will counsel this physician on the lack of clear documentation of the change in treatment plan.<br><br>**Monitoring:**<br>• For the next 30 days, Monday through Friday, quality improvement staff will review ten randomly selected open medical records in the ED to validate that consults were performed by a physician and that there is a consulting physician's note. The Chair of the responsible Department will be notified of discrepancies for immediate corrective actions.<br>• Ten randomly selected ED records of patients who received a consult, including those who received consults on the weekends will be reviewed each week to validate that all consults were performed by a physician and that there is a consulting physician's note. The Chair of the responsible department will be notified of discrepancies for corrective actions. Results of these audits will be presented to Performance Improvement Committee, which will review and create corrective action as necessary. The data will then be reported to Executive Committee.<br><br>**Position Responsible:**<br>ED Medical Director<br>Interim Chief Medical Director | 6/19/07<br><br>6/19/07 |

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| | | | At 1435 the patient was transferred to radiology for an additional test, a CT scan. | 6/18/07 |
| | | | o The Nurse Manager of Women's and Child Health will provide inservice training on the proper documentation to avoid misleading entries to all nursing staff.<br><br>**Monitoring:**<br>Ten randomly selected ED medical records will be reviewed each week to assure clear documentation of patient care events. Results of this audit will be presented to the Performance Management Committee which will review and create corrective actions as necessary. The data will then be reported to the Executive Committee.<br><br>**Position Responsible:**<br>Chief Nursing Officer | |

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| A 455 | Continued From page 9<br>results were not available for diagnosis and/or treatment until 1700 hours; 6 and 1/2 hours after Patient C presented to the ED.<br><br>5. The medical record for Patient E documented he presented to the ED at 1139 hours on 5/11/07 with left flank pain. He was not seen by a triage nurse until three hours later to determine the severity of his symptoms. At 1448 hours, the triage nurse documented his pain was 8/10. At 1730 hours the nurse documented the first full assessment of the patient. The patient was evaluated by a physician's assistant. There was no documented evidence a physician saw Patient E. Pain medication was not administered to Patient E until 2100 hours, 9 and 1/2 hours after he presented to the ER. No further treatment was provided to Patient E and it was documented that he eloped from the ED at 0000 hours on 5/12 /07.<br><br>6. The medical record for Patient F identified that he came to the ED at 1812 hours on 5/11/07 for a "surgical consult for (his) umbilical hernia." He was triaged at 1845 and complained of 5/10 pain. When he was called to the treatment area four hours later he did not answer. At 0100 the nurse documented the patient left without being seen. No medical screening examination had been performed to determine if the patient had a medical emergency condition.<br><br>7. The medical record for Patient G showed she presented to the ED at 2045 hours on 5/11/07 for "spotting" during her pregnancy. She stated she was 2 months pregnant. At 2140 hours she was triaged and a pregnancy test was documented as positive. When the patient was called to the treatment area 2 hours later, she had left without | A 455 | **Immediate Actions – Patient E:**<br>• The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain, which requires intervention based on the pain policy. This information must be documented in the patient's medical record. (Attachment S)<br>• A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triaging process was re-designed to provide for a more timely medical screening examination. This process includes the following:<br>o The triage nurse and registration clerk are co-located so that the triaging process and the registration process can occur simultaneously.<br>o A physician will be available to the triaging area to perform immediate medical screening examinations for patients who are identified as a level 3. Upon completion of the medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out.<br>o Patients who are identified as a Level 1 and 2 at the time of triage will be brought back to the emergency treatment area. At the time of arrival, the ED charge nurse will notify the physician of the patient's arrival by placing the patient's pseudo name on the white board along with the patient's priority number. The physician will acknowledge the patient by initialing the white board and will perform the medical screening examination as soon as possible. If a patient's condition is critical, the RN will verbally notify the physician. | 6/19/07 |

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| A 455 | Continued From page 9<br>results were not available for diagnosis and/or treatment until 1700 hours; 6 and 1/2 hours after Patient C presented to the ED.<br><br>5. The medical record for Patient E documented he presented to the ED at 1139 hours on 5/11/07 with left flank pain. He was not seen by a triage nurse until three hours later to determine the severity of his symptoms. At 1448 hours, the triage nurse documented his pain was 8/10. At 1730 hours the nurse documented the first full assessment of the patient. The patient was evaluated by a physician's assistant. There was no documented evidence a physician saw Patient E. Pain medication was not administered to Patient E until 2100 hours, 9 and 1/2 hours after he presented to the ER. No further treatment was provided to Patient E and it was documented that he eloped from the ED at 0000 hours on 5/12 /07.<br><br>6. The medical record for Patient F identified that he came to the ED at 1812 hours on 5/11/07 for a "surgical consult for (his) umbilical hernia." He was triaged at 1845 and complained of 5/10 pain. When he was called to the treatment area four hours later he did not answer. At 0100 the nurse documented the patient left without being seen. No medical screening examination had been performed to determine if the patient had a medical emergency condition.<br><br>7. The medical record for Patient G showed she presented to the ED at 2045 hours on 5/11/07 for "spotting" during her pregnancy. She stated she was 2 months pregnant. At 2140 hours she was triaged and a pregnancy test was documented as positive. When the patient was called to the treatment area 2 hours later, she had left without | A 455 | **Monitoring:**<br>• Ten randomly selected medical records will be reviewed daily to track the time from triage to medical screening examination. Data from these daily reviews will be presented to the ED Collaborative Practice Committee and the process will be re-evaluated as a result of this review. Data will also be presented to the Performance Improvement Committee monthly, which will evaluate it, develop corrective actions as necessary, and report it to the Executive Committee and as appropriate to the governing Body. Once the Executive Committee concludes that the process is stable, the daily record review will convert to a monthly review.<br><br>**Position Responsible:**<br>ED Medical Director<br>ED Nurse Manager | |

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| A 455 | Continued From page 10<br>being seen to determine if an emergency condition existed. She returned to the ED at 1306 hours on 5/14/07 with a complaint of vaginal bleeding for three days. She had 8/10 pain when triaged by the nurse at 1315. There was no documented evidence the ED nurse evaluated how much the patient was bleeding. She was not taken to the treatment area until four hours later at 1730 hours. No pain medication/intervention was given. Her medical screening exam was conducted by a physician's assistant. She passed the products of conception while having an ultrasound done and was discharged by a physician at 2235 hours after having had a miscarriage.<br><br>8. Patient O came to the ED of the hospital on 4/30/07 at approximately 1207 hours. When triaged at 1250 hours she identified she had sharp pain of 10 on a 1-10 scale. No pain intervention were initiated in the triage area. The patient was taken to the treatment area five hours later at 1815 and received pain medication one hour later. Approximately 20 hours after she presented to the ED, at 0830 hours on 5/1/07, a general surgery consultation was provided to evaluate the acute abdominal pain for Patient O. The closed medical record for Patient O revealed "Dr."at bedside. However, review of the record revealed that the general surgery consultation had been provided by a Physician Assistant (PA-C). There was no documentation to reveal that provision of emergency consultations by a PA-C was approved and consistent with the rules and regulations, the medical staff bylaws of the hospital, and the credentialing process of a mid-level practitioner. The patient was admitted to the hospital and had surgery for an exploratory laparotomy ventral hernia repair. | A 455 | **Monitoring:**<br>• Ten randomly selected medical records will be reviewed daily to track the time from triage to medical screening examination. Data from these daily reviews will be presented to the ED Collaborative Practice Committee and the process will be re-evaluated as a result of this review. Data will also be presented to the Performance Improvement Committee monthly, which will evaluate it, develop corrective actions as necessary, and report it to the Executive Committee and as appropriate to the governing Body. Once the process is stable, the daily record review will convert to a monthly review.<br><br>**Position Responsible:**<br>ED Medical Director<br>ED Nurse Manager<br>Interim Chief Medical Officer | |

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| A 455 | Continued From page 10<br>being seen to determine if an emergency condition existed. She returned to the ED at 1306 hours on 5/14/07 with a complaint of vaginal bleeding for three days. She had 8/10 pain when triaged by the nurse at 1315. There was no documented evidence the ED nurse evaluated how much the patient was bleeding. She was not taken to the treatment area until four hours later at 1730 hours. No pain medication/intervention was given. Her medical screening exam was conducted by a physician's assistant. She passed the products of conception while having an ultrasound done and was discharged by a physician at 2235 hours after having had a miscarriage.<br><br>8. Patient O came to the ED of the hospital on 4/30/07 at approximately 1207 hours. When triaged at 1250 hours she identified she had sharp pain of 10 on a 1-10 scale. No pain intervention were initiated in the triage area. The patient was taken to the treatment area five hours later at 1815 and received pain medication one hour later. Approximately 20 hours after she presented to the ED, at 0830 hours on 5/1/07, a general surgery consultation was provided to evaluate the acute abdominal pain for Patient O. The closed medical record for Patient O revealed "Dr."at bedside. However, review of the record revealed that the general surgery consultation had been provided by a Physician Assistant (PA-C). There was no documentation to reveal that provision of emergency consultations by a PA-C was approved and consistent with the rules and regulations, the medical staff bylaws of the hospital, and the credentialing process of a mid-level practitioner. The patient was admitted to the hospital and had surgery for an exploratory laparotomy ventral hernia repair. | A 455 | **Corrective Actions – Patient O:**<br>• The Chief Medical Officer notified the ED Medical Director that physician assistants shall no longer perform medical screening examinations. (Attachment A)<br>• The ED Medical Director informed each physician assistant, by e-mail, that they may no longer perform medical screening examinations.<br>• The ED Nurse Manager provided education to all ED RNs on the requirement to notify physicians of all patients waiting to be seen that are experiencing pain which requires intervention based on the pain policy. This information must be documented in the patient's medical record.<br>• A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triaging process was re-designed to provide for a more timely medical screening examination. This process includes the following: (Attachment O)<br>o The triage nurse and registration clerk are co-located so that the triaging process and the registration process can occur simultaneously.<br>o A physician will be available to the triaging area to perform immediate medical screening examinations for patients who are identified as a level 3. Upon completion of the medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out. | |

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| A 455 | Continued From page 11<br><br>9. Patient P came to the emergency department on 4/30/07 at approximately 1000 hours for the evaluation of a known ectopic pregnancy. At 1800 hours an nursing interval note indicated that the emergency department was unable to admit Patient P to the hospital "due to short staff". There was no nursing or physician documentation to indicate intervention to evaluate the appropriate provision of care for Patient P. The patient was admitted to an in-patient bed at 2100 hours.<br><br>10. Patient Q came to the emergency department of the hospital at approximately 2040 hours on 4/30/07. Patient Q stated that he was seeing aliens and devils. He was dropped off by his family. At triage the nurse documented the patient had suicidal ideations with a plan to drink bleach. The nurse triaged the patient as a category 3 (stable major illness) and left him in the lobby for over one hour before taking him back to the treatment area. Patient Q was evaluated by the emergency department physician at 0500 hours on 5/1/07, a delay of almost 7 hours. No psychiatric treatment or consultation was provided. Approximately 6 hours later, at 1055 hours on 5/1/07, an evaluation by a mental health professional was requested. The mental health evaluation was not completed until four hours later at 1500 hours; 17 hours after he presented to the ED. The mental health professional determined the patient denied being suicidal at the time of the evaluation. Patient Q was discharged home at 2100 hours without receiving treatment. The hospital thus failed to ensure that the provision of emergency services had been provided within timeframes consistent with acceptable safety for psychiatric patients. | A 455 | **Corrective Action – Patient P:**<br>See cover letter.<br><br>**Corrective Action - Page Q:**<br>• A multidisciplinary team of ED physicians and ED nurses reviewed the current triage process. As a result of that review, the triaging process was re-designed to provide for a more timely medical screening examination. This process includes the following: (Attachment O)<br>o The triage nurse and registration clerk are co-located so that the triaging process and the registration process can occur simultaneously.<br>o A physician will be available to the triaging area to perform immediate medical screening examinations for patients who are identified as a level 3. Upon completion of the medical screening examination, based on the patient's clinical presentation, tests and treatments (including pain management) will be ordered and carried out.<br>o Patients who are identified as a Level 1 and 2 at the time of triage will be brought back to the emergency treatment area. At the time of arrival, the ED charge nurse will notify the physician of the patient's arrival by placing the patient's pseudo name on the white board along with the patient's priority number. The physician will acknowledge the patient by initialing the white board and will perform the medical screening examination as soon as possible. If a patient's condition is critical, the RN will verbally notify the physician. | |

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| A 455 | Continued From page 12<br><br>11. Patients H, I, J, K, L, M and N were evaluated on 5/30 or 5/31/07 at triage and sent to the Urgent Care area of the emergency department. Each patient was examined and treated by a Physician Assistant, PA-C. When reviewed, each medical record revealed that the patients had been evaluated, treated and discharged from the Urgent Care of the hospital prior to the time of supervision or monitoring by the emergency department physician. The facility failed to ensure that direct supervision of a mid-level practitioner had been provided. The medical record for each patient failed to demonstrate a timed entry by the emergency department physician. When interviewed on 5/31/07 at approximately 1030 hours, the PA-C readily admitted that a medical screening examination, provided by the PA-C was unsupervised. When reviewed, there was no documentation in the rules and regulations, or medical staff by laws delineating such privileges for the PA-C. There was no documentation present in the PA-C privileging forms to assess their qualifications and competence to provide medical screening examinations in the emergency department and/ or to determine if an emergency medical condition existed. | A 455 | **Corrective Action – Patient H,I,J,K,L,M & N:**<br>• The Chief Medical Officer notified the ED Medical Director that physician assistants shall no longer perform medical screening examinations. (Attachment A)<br>• The ED Medical Director informed each physician's assistant, by e-mail, that they may no longer perform medical screening examinations.<br><br>**Monitoring:**<br>• Ten randomly selected medical records will be reviewed daily to ensure that the medical screening exam is documented by an attending physician. Data will be presented to the Performance Improvement Committee and to the Executive Committee. Once the Executive Committee concludes that the process is stable, the daily record review will convert to a monthly review.<br><br>**Position Responsible:**<br>ED Medical Director | 6/12/07 |